Health Home Planning Workgroup
Meeting minutes for August 27, 2012 meeting
AmericInn, Fort Pierre, SD

Members in attendance: David Flicek, Dr. Tad Jacobs, Scot Graff, Rod Marchiando, Tony Tiefenthaler, Dave Hewett, Terry Dosch, Colleen Winter, Barb Smith, Nicole Bartel, Amy Iversen-Pollreisz, Kim Malsam-Rysdon, Kathi Mueller, Representative Suzy Blake, Senator Corey Brown, Senator Jean Hunhoff, Senator Deb Peters and Lynette Huber

Others in attendance: Deb Fischer-Clemens,Jean Reed, Megan Cormier, Sandy Crisp, Ann Schwartz, Kurt Stone, Brian Pederson, Leah Ahartz, Larry Shireley, Alan Solano, Jill Franken, John Mengenhausen, Jesse Smith, Ruth Krystopolski, Shawn Nills, Terri Carlson,Sue Cichos and Heather Cuny

Members Absent: Dana Darger, Representative Justin Cronin, Deleen Kougl and Sonja Weston

Meeting minutes:
Kim Malsam-Rysdon opened the meeting with an overview of who South Dakota Health Homes will be geared toward and explained that the approach is to be as expansive as possible. Next, the group reviewed decisions the Workgroup has agreed upon to date.

Decisions to date:
The first decision reviewed was the population to be served by the two South Dakota Health Homes. The Primary Care Provider (PCP) Health Home will serve Medicaid recipients with **two or more chronic diseases OR recipients with one chronic condition and at risk for another chronic condition:** Chronic diseases include: Asthma, COPD, Diabetes, Heart Disease, Hypertension, Substance Abuse, Obesity, and HIV. At-risk conditions include: Pre-Diabetes, tobacco use, Cancer Hypercholesterolemia, Depression, and use of multiple medications (6 or more classes of drugs).

The Behavioral Health (BH) Health Home includes recipients with **one Severe Mental Illness or Emotional Disability:** Schizophrenia, Bipolar, major depression, Mood Disorders, Ethyl Alcohol-related Psychotic Disorders, anxiety, personality/social disorders, Attention Deficit Hyperactivity Disorder.

Based on data analysis the Financial Workgroup identified higher than expected prevalence of Muskoloskeletal and Neck/Back disorders among people with high costs in the Medicaid Program. This clinical category would add approximately 3064 recipients to the potential Health Home population.

The second decision reviewed was the Provider Infrastructure. The group had previously chosen two of the three Provider Infrastructure options outlined in the CMS regulations. The first infrastructure option chosen was the Designated Provider. A Designated Provider was defined as follows: Physician (MD, DO), Nurse Practitioner, Physician Assistant Clinic Group Practice, rural health clinic, community health center, community mental health center or other behavioral health provider, Pediatrician or OB/GYN.

The second infrastructure option chosen was the Team of Health Care Providers. The Team of health Care Providers consists of a broader group of health and community based professionals and was defined as follows:

> Health Coach, Care Coordinator, Chiropractor, Pharmacist, Support Staff, Community Mental Health Center or other behavioral health provider, Other Community Services, Others as appropriate

After some discussion, it was suggested that in the Designated Provider, the reference to specific specialties (pediatrician or OB/GYN) be eliminated as these specialties are already covered in the definition of a Physician. With this change, the Workgroup reaffirmed their approval of the Provider Infrastructure.

DSS staff also reviewed with the Workgroup other items that are foundational to Health Homes to ensure all Workgroup members had a common understanding. These included the following:

- A Health Home is different than a patient centered medical home;
- Health Homes are specific to a defined Medicaid population rather than the entire population;
- Health Homes are disease focused rather than population focused;
- Health Homes requires the provision of CMS designated Core Services;
- A PMPM will be created to cover the services currently not billable under Medicaid;
- 90/10 funding is limited to funding the additional core services required to be a health home. It does not cover existing services:
- Recipients dually eligible for Medicare and Medicaid cannot be excluded from Health Homes. They were excluded from the initial data analysis, because they skew the results in terms of cost. Dual recipients would add 9,445 eligible recipients to the potential Health Home population; and
- Kids cannot be excluded from the BH Health Home.

Financial Subgroup Recommendation:

Kim Malsam-Rysdon and Megan Cormier of Sellers Dorsey reviewed the recommendations from the Financial Subgroup with the overall Workgroup. They explained that the Subgroup recommended a Tiered PMPM rather than a Flat Rate. In coming to this recommendation, the Financial Subgroup discussed three methodologies for developing the Tiers for Health Home recipients. After a review of the three methodologies, the Subgroup recommended that the Tiers be based on the Chronic Illness and Disability Payment System (CDPS). It was explained that CDPS is a publicly available tool validated for use in Medicaid populations, developed by the University of California San Diego. States that use Medicaid Managed Care Companies to manage their populations include Washington, Utah, Delaware and Michigan. CDPS accounts for a broad spectrum of diseases (not just those included in HH definition) and historical costs in order to predict risk for future high costs. CDPS stratifies each diagnostic category into hierarchical levels of severity that demonstrate the level of healthcare needs of a recipient with a diagnosis within a given category.

The detailed data that supports the Financial Subgroup recommendation was presented to the entire Workgroup. This included a description of the population data reviewed and the analysis results. The data analyzed was for 1/1/2011 – 12/31/2011 and included 141,504 recipients with a $700M total cost of care. The costs excluded from the analyses were maternity and newborns (n=22,513 recipients, $106M), and dual

recipients (n = 14,845 recipients, $243M). The results of the analysis revealed that 104,146 recipients remained with a $351M cost of care. The analysis revealed information about the total population of Medicaid recipients, the 29,636 recipients eligible for Health Homes (n= 8,784 PCP; n=20,852 SMI) and the 79,409 recipients not eligible for Health Homes. The analysis also identified that 5% of the population drives 56% of the total cost. It was also shared that 83% of individuals eligible for Health Homes were also in the top 5%. The remaining 17% of the recipients in the top 5% were not eligible because they did not meet the definition of having the conditions necessary to be served by a health home.

Next the group reviewed a revised analysis that included the expanded population the Financial Subgroup had recommended. The revised analysis demonstrated 35,685 potential recipients are eligible for Health Homes with 19,185 eligible for a primary care provider (PCP) Health Home and 26,078 eligible for a behavioral health (BH) Health Home. There were 9,578 recipients who would be potentially be eligible for both the PCP and BH Health Homes. Additionally, 9,445 Duals (not originally included) are eligible for Health Homes.

The Workgroup agreed to add the expanded population of recipients with Musculoskeletal and Neck/Back Disorders which included 3,064 recipients that were not originally included in the analysis. Geo-mapping of the expanded population was reviewed for both the PCP and BH Health Homes. The geo-mapping of recipient volume was compared to the locations where preliminary interest was expressed. DSS agreed to share Geomapping by Tier for each county and the MSA areas. Workgroup members agreed to again review their preliminary locations and compare it to the recipient volume and assess their continued interest in that specific location and determine if potentially there are other locations to be considered.

The final portion of the financial discussion focused on potential tier models for both the PCP and BH Health Homes. The Financial Subgroup had requested that a three, four and five tier model be developed. The tiering was developed based on the recipients' CDPS scores. After a review of the three models, the group agreed to operate under a four-tier model. It was noted that in the four-tier model, Tier 1 recipients had a CDPS score of 1.0547043. This indicated that this population is functioning at a more normal level and it is safe to assume that their needs are being met through current Medicaid programs. DSS staff indicated that it was unlikely that the State would pay the Health Home for additional services for this group as a need is not present at this time. The Workgroup was informed that information would be gathered through a prospective cost report to define the amount of each tier's PMPM.

An additional recommendation of the Financial Subgroup was the inclusion of a shared savings methodology within the reimbursement methodology. There was extensive discussion on this topic and in summary it was agreed that to be able to develop a shared savings model, actual data was needed and that shared savings could be phased in over time. The State did commit to including information in the State Plan Amendment that their intent was to evaluate implementing a shared savings model in future years of the Health Home program. There was a brief discussion as to how shared savings could be utilized. One suggestion was to reinvest the dollars back into the Medicaid program.

In summary, the Workgroup accepted the recommendation of the Financial Workgroup to expand the population as defined earlier, to operate under a four tier system and to delay a shared savings model until analysis that can be based on actual data can be performed.

Implementation Parameters:
Kathi Mueller explained that the Health Home implementation sites will allow DSS to determine where health homes are a useful model to manage patients with high health care needs. The implementation phase also supports the testing of different models with representation of our different geographic areas, (Urban, Rural, and Frontier) and representation of various provider types (Indian Health Service, Tribal, Physician-led, Midlevel-led, system owned and independent). The implementation sites should provide coverage in all high health home population areas if possible. Additionally, the pilots will present opportunities for provider collaboration. To ensure that all of these goals are achieved during the pilot phase, it was suggested that an Implementation Subgroup be established to provide input on implementation. The group agreed this was the right direction and members volunteered to serve on the Implementation Subgroup. It was agreed that the Implementation Subgroup would meet September 24, 2012 from 9:30 to 12:00 CT in Pierre and if necessary again on October 9, 2012 from 9:30 to 12:00 CT in Pierre.

Core Services
Jean Reed walked the workgroup through the Health Home Core Services material that had been provided for their review and consideration prior to the meeting. It was noted that all Health Homes are required to provide each of the six following Core Services.

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Patient and Family Support
- Referrals to Community and Social Support Service

Based on the regulations, Health Homes have some flexibility in how the Core Services are defined and who is expected to deliver the services. Each of the Core Services was reviewed. At the conclusion of this review, the Workgroup accepted the Core Services as presented.

Recommendation of the Outcome Measure Subgroup
Jean Reed walked the workgroup through the recommendation of the Outcome Measure Subgroup material that had been provided for their review and consideration prior to the meeting. It was explained to the Workgroup that the State Plan Amendment requires DSS include in the SPA Health Home Goals with specific measures in the area of Clinical Outcomes, Experience of Care, and Quality of Care. To meet this requirement the Outcome Measure Subgroup recommended three different goals with appropriate measures for PCP and BH Health Homes. The goals and measures were based on the work of other states, measures already being used by facilities and the essential provider criteria outlined by NCQA. It was also noted that the State would complete two different State Plan Amendments (SPAs) for primary care and behavioral health health homes with goals and measures that were developed for each. In general there is a minimum of one clinical indicator for each disease category, patient and family experience/satisfaction measures and cost/effectiveness measures. Each measure is then tied to a Core Service as a means to evaluate Health Home performance.

All of the indicators plus two specific Patient and Family support indicators were reviewed. At the conclusion of the review, the Workgroup accepted the Outcome measures as presented.

Provider Standards
The State Plan Amendment requires that States outline what the Provider Standards are for Heath Home participation. The Standards had been provided to the group prior to the meeting for their review and consideration. After some discussion, the Provider Standards were approved as presented however there were logistical questions as to how the process would flow. It was agreed that this would be addressed through the Pilot Implementation Subgroup.

Other Updates
Tony Tiefenthaler provided the Workgroup with an update on the Sanford One Care Grant and Colleen Winter provided the Workgroup with an update on the Department of Health's Chronic Disease Self Management program.

Next Steps
The Workgroup discussed the next steps of the overall process. This includes the following:

- Gathering of additional data to calculate the PMPM.
- Completion of the State Plan Amendment which requires consultations with CMS and SAMHSA
- Drafting the Amendment
- Allow for a 30 day tribal comment period and public notice.
- Submission to CMS (CMS has 90 days to review and approve).

Next scheduled meetings

- **Implementation Subgroup will meet September 24, 2012 from 9:30 to 12:00 CT in Pierre and if necessary on October 9, 2012 from 9:30 to 12:00 CT in Pierre.**
- **Next Workgroup Meeting is scheduled for October 30, 2012, from 10:00 am to 3:00 pm in Ft. Pierre. Materials will be sent prior to the meeting.**